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Eliciting lay beliefs across cultures: principles and methodology

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Abstract Lay beliefs about illness, its causes and its treatment, do not necessarily concur with medical knowledge, and can sometimes be highly idiosyncratic. These beliefs are likely to be influential in help-seeking, in patients' attitudes to professional help, and in the manner in which patients participate in the management of their illness. Clinicians thus need to understand such lay beliefs and attitudes in order to engage their patients in treatment and to provide optimal care. Lay beliefs are likely to be influenced by the individual's culture and hence also by ethnic group. In attempting to understand the patient's beliefs, the researcher or clinician runs the risk of ethnocentricity - viewing the patient's culture inappropriately from the clinician's own perspective. In some senses, this applies to every clinical encounter - patient and clinician always come from different cultures, in the broad sense. Sensitive clinicians develop expertise at bridging this cultural gap and seeing the patient's problems from the latter's viewpoint. However, more systematic investigation of beliefs and attitudes within a given culture can be pursued using the anthropological technique of ethnography. Ethnographic interviewing can yield qualitative data which can then be taken further in quantitative studies. To minimise the risks of ethnocentricity, it may be appropriate to analyse such data not using customary statistical methods but non-linear multivariate data analysis.

Lay beliefs and attitudes

The decisions which people take about their health, such as when to seek help because of illness and from whom, are based on their own beliefs and attitudes. These in turn are influenced by numerous factors, such as past personal and family experience of illness and professional help, other contacts with health professionals, and information and advice from relatives, friends and the media. The Health Belief Model summarises these influences well,[1] although it would be more accurately described as the Illness Beliefs Model. Some of these factors are in theory accessible to a wide cross-section of the population, for example, information from the media. However, people differ in the extent to which they avail themselves of such information, and how they might interpret it. For example, despite continuing publicity, a recent survey of people with cancer living in a poor area of the United States revealed that nearly one third did not link cigarette smoking with cancer.[2] Other factors, particularly personal and family beliefs, are less likely to be shared, and are therefore more difficult to anticipate or predict. For example, where there is a strong family history of a particular illness, an individual's beliefs about treatment and outcome may be influenced by recollections of a parent or even a grandparent, whose management some years ago has often been superseded by more effective treatments. Sometimes, personal beliefs about illness can be highly idiosyncratic.[3,4]

Cultural influences on lay beliefs

Culture is a property of society. Helman[5] defines culture as *a set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to view the world ... and how to behave in it in relation to other people.* As Helman stresses, there is no such entity as a 'pure' culture. Societies are inevitably heterogeneous. Within any society exist numerous subcultures, defined in terms of education, religion, socioeconomic factors, and so on. One important feature of any cultural group is that values and attitudes deemed important within that culture are passed on from one generation to the next. Illness and death are important concepts in all cultures, and attitudes towards these are therefore likely to be culturally laden. It would therefore seem reasonable to attempt within a given culture to identify commonly held beliefs or attitudes. However, in practice, this process is more complex. Every culture is characterised by boundaries which distinguish those within the culture from those outside it. Exploration of culturally determined beliefs depends on the adequate definition of these boundaries. In examining the effect of culture on illness in general, there is the added complication that the boundaries relevant to culture may not coincide with those considered important to the illness. For example, one might imagine that Hindus constituted a discrete cultural group. However, a study of Hindus in Britain would need to take account of numerous factors which are potentially confounding. For example, those born and educated in Britain might have beliefs which are very different from those of older Hindus who migrated to Britain.

Such difficulties are often manifestations of a more general problem for those engaged in research across cultures, namely *ethnocentricity* - the interpretation of one culture using the norms of another (the researcher's own).[6] This problem is inherent in many commonly used research techniques. For example, if a research study is designed to test a particular hypothesis, would that hypothesis make sense to the culture being investigated? A study designed to determine whether Hindus who were ill chose to see a physician or a traditional healer depends on the assumption that informants would choose one or the other of these. Pursuing a consistent model of illness is common among clinicians, but lay people often find no need to choose between models, sometimes simultaneously pursuing several even when they conflict.

Eliciting beliefs across cultures

The essential principle in developing an understanding of a person's beliefs is to try to understand the world (or at least relevant parts of it) through that person's eyes. This involves suspending one's own belief systems and exploring the other person's beliefs as a naive observer would. This is an important component of ethnography, an anthropological technique for understanding culturally defined beliefs and attitudes, which has been used in medicine to gather information mainly about the cultural context of illness and help-seeking. In the ethnographic interview, the lay informant is treated as the expert and the interviewer does not pursue any *a priori* assumptions.[7] A variety of techniques can be used to achieve these aims, and a skilled interviewer can thus reduce the risks of ethnocentricity.

One crucial skill is the development of *translation competence,*[7] being able to elicit beliefs and meanings in one culture and translating these into a form understood in another. This is clearly required when interviewer's and informant's native languages are different. However, this is only an extreme example of a universal phenomenon in clinical practice and research. Even if doctor and patient share a common native language, they belong to different cultures.[8,9] The clinical interview represents a cross-cultural exchange between a lay person and a professional. In response to the question *how long have I got,* the doctor needs to translate

from the language of survival curves, odds ratios and probabilities into terms comprehensible by the patient. In this example, it may be obvious to both parties that translation is necessary. This may not apply when eliciting lay beliefs. The skilled ethnographic interviewer learns the informant's vocabulary and idioms, and uses these to elicit beliefs and meanings. The interviewer may have some idea of what an informant means when reporting that his *head feels heavy,* but suspends judgement until further details of the meaning have been elicited from the informant.

The ethnographic interview appears far removed from clinical practice. However, as noted above, some of its components are apparent in every effective clinical encounter. Also, some of the principles on which it is based are shared with cognitive therapy, which is becoming increasingly used in clinical practice with the physically ill,[4,10] including those with cancer.[11,12] Cognitive therapy again involves seeing the interviewee as expert in his or her own model of illness and concerns. Cognitive therapy techniques can be extremely helpful in identifying the models of illness which patients hold, and their coping strategies. Some of the methods used by clinical psychologists to develop measures of beliefs or attitudes would probably be viewed by anthropologists as applications of ethnographic interviewing. Viewing them as such serves to emphasise their transcultural nature.

Quantitative methods

The ethnographic interview is a qualitative technique. Usually, a small sample of people is interviewed in depth. From the examination of common and/or important themes from such a sample of ethnographic interviews, the researcher can identify particular beliefs or frameworks which might be worth further examination. Content analysis of the interviews[13] may contribute in this process, and can in some instances be assisted by specialised computer software.[14]

Beliefs derived in this way are far more likely to be culturally pertinent than those generated by clinicians or researchers on behalf of their patients. There is considerable evidence that clinicians' views of their patients' beliefs are not necessarily accurate (see below) and probably subject to ethnocentricity. Theoretically at least, this problem applies to many published surveys of attitudes to cancer or beliefs about it.

Once a series of questions has been formulated using a culturally sensitive method, these can be tested further in a different sample, for example in a questionnaire survey which can yield quantitative data. However, analysis of such data requires careful thought. Standard statistical methods are based on the testing of specific hypotheses. Determining which hypotheses to test again runs the risk of ethnocentricity. For example, in a sample of people from the Indian subcontinent, is it more appropriate to examine differences according to religious group or mother tongue? Should the subgroups be split by gender, or can it be assumed that differences between men and women will be overshadowed by the other factors under investigation? A method of avoiding these problems is to use some form of non-linear multivariate analysis,[15] such as correspondence analysis[16] or multidimensional scaling.[17] These are methods of aggregating data comprising multiple variables (usually categorical) which produce a concise geometric representation (which can be represented graphically) of the associations between variables in orthogonal dimensions. Unlike customary statistical techniques, such methods of data analysis describe the patterns inherent in the data without making any *a priori* assumptions, and hence complement well the principles of ethnography. The resultant patterns of variables can then form the basis of specific hypotheses which can then be pursued in further studies.

Figure 1 shows an example of correspondence analysis. Itrepresents the output of a study, conducted using the methods described, of lay beliefs among people of Indian or Pakistani origin about the causes and management of common mental symptoms.[16] The variables include mental problems (indicated by the symbol ●), perceived causes (indicated by ○) and recommended management (in italics, indicated by ▲). The distances between variables give a measure of how dissimilar the variables are. The symptom *body feels heavy* is quite different from *hearing voices* and *has a drink problem.* Of possible causes for mental problems, *curse* or *evil* eye appears associated with hearing voices, while *bad treatment by the family* is more closely associated with having a drink problem or losing affection for one's children. In terms of help-seeking, the data suggest several interesting hypotheses to pursue. For example, a general practitioner's advice is recommended for complaints that appear relatively vague, while symptoms considered to originate inside the mind might not warrant seeing a specialist. Very few of these possible associations were evident from simple cross-tabulations performed on the data.

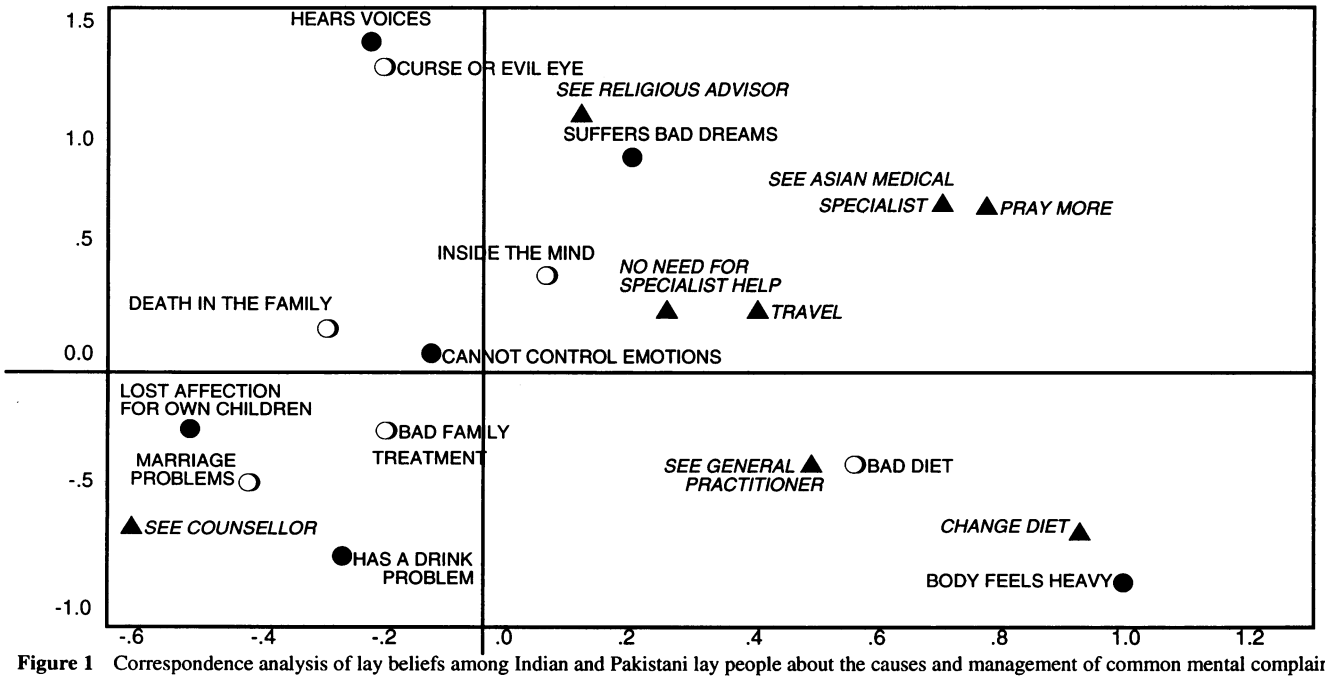

Figure 1 Correspondence analysis of lay beliefs among Indian and Pakistani lay people about the causes and management of common mental complaints

Relevance to clinical practice of better cross-cultural understanding

Providing patients and their families with the best possible treatment depends on clinicians understanding when and why their patients seek help, and what their particular concerns might be regarding the illness and its management. This requires an understanding of lay beliefs and how to elicit them. While this may sometimes be a particular problem in treating patients from minority cultures, it is both accurate and helpful to view every clinical interview as a cross-cultural exchange. Almost all patients have a personal theory of the cause of cancer,[18] which can be markedly affected by culture,[2,19] and which can influence the patient's concerns, and collaboration with treatment. Oncologists can be very sensitive to their patients' emotions and concerns.[20] However, even when patient and clinician belong to the same ethnic group, their beliefs about the clinical encounter do not necessarily concur. For example, some clinicians may be surprised that hardly any patients believe that they should have implicit trust in their doctors,[21] or that one reason why patients may not discuss emotional problems at their appointments is because the patients believe that this would take time away from discussing more urgent matters.[22] Such beliefs are probably widespread, but our knowledge and understanding of them remains rudimentary, often coming from research designed to test specific hypotheses framed in the language of researcher or clinician. Pursing this research further by adopting techniques such as those described above offers the opportunity to identify a wider range of salient beliefs and attitudes. These methods could provide information informing routine clinical practice. They could also contribute to public health aspects of cancer by, for example, shedding light on the perceived reasons why some patients with cancer present later than others, or why some but not others are likely to take advantage of screening programmes or other preventative measures. In this regard, the real question is not *"What do you tell your patients?"* but rather, *"What do you let your patients tell you?"*[23]

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